

		FOR OHF USE					

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**2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0031757</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>WEST MAIN NURSING HOME</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/00</u> to <u>9/30/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>1224 WEST MAIN STREET</u> <u>MASCOUTAH</u> <u>62258</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>ST. CLAIR</u>		Officer or Administrator of Provider	
Telephone Number: <u>618-566-7327</u> Fax # ()		(Signed) _____ (Date) _____	
IDPA ID Number: <u>0031757</u>		(Type or Print Name) <u>JAMES J. GIARDINA</u>	
Date of Initial License for Current Owners: <u>12/23/86</u>		(Title) <u>PRESIDENT</u>	
Type of Ownership:		(Signed) _____ (Date) _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____		Paid Preparer	
In the event there are further questions about this report, please contact: Name: <u>YVONNE CHUA</u> Telephone Number: <u>636-394-3000</u>		(Print Name and Title) <u>DARRYL E. BUEKER, CPA</u> (Firm Name & Address) <u>BKD, LLP</u> <u>PO BOX 1190, SPRINGFIELD, MO 65801-1190</u> (Telephone) <u>417-865-8701</u> Fax # <u>417-865-0682</u>	
		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

Facility Name & ID Number WEST MAIN NURSING HOME# 0031757 Report Period Beginning: 10/1/00 Ending: 9/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>34</u>	Intermediate (ICF)	<u>34</u>	<u>12,410</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>34</u>	TOTALS	<u>34</u>	<u>12,410</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>10,676</u>	<u>686</u>	<u>12</u>	<u>11,374</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,676</u>	<u>686</u>	<u>12</u>	<u>11,374</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 91.65%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 12/23/86

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 12/23/86 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 9/30/01 Fiscal Year: 9/30/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number

WEST MAIN NURSING HOME

0031757

Report Period Beginning:

10/1/00

Ending:

9/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	64,771	2,926	3,363	71,060		71,060		71,060		1
2	Food Purchase		40,673		40,673		40,673	(43)	40,630		2
3	Housekeeping	39,380	3,882		43,262		43,262	30	43,292		3
4	Laundry	16,249	8,580		24,829		24,829		24,829		4
5	Heat and Other Utilities			27,554	27,554		27,554		27,554		5
6	Maintenance	7,753	11,104	16,474	35,331		35,331	139	35,470		6
7	Other (specify):*										7
8	TOTAL General Services	128,153	67,165	47,391	242,709		242,709	126	242,835		8
	B. Health Care and Programs										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	241,937	34,358	221,628	497,923	(1,186)	496,737		496,737		10
10a	Therapy	5,624		6,297	11,921		11,921		11,921		10a
11	Activities	23,660	6,767	2,906	33,333		33,333		33,333		11
12	Social Services	5,719	37	1,020	6,776		6,776		6,776		12
13	Nurse Aide Training										13
14	Program Transportation			165	165		165		165		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	276,940	41,162	236,816	554,918	(1,186)	553,732		553,732		16
	C. General Administration										
17	Administrative	42,806			42,806		42,806	23,293	66,099		17
18	Directors Fees										18
19	Professional Services			41,470	41,470		41,470	(35,050)	6,420		19
20	Dues, Fees, Subscriptions & Promotions			8,251	8,251		8,251	(2,818)	5,433		20
21	Clerical & General Office Expenses		1,737	7,125	8,862		8,862	22,614	31,476		21
22	Employee Benefits & Payroll Taxes			65,604	65,604		65,604	4,963	70,567		22
23	Inservice Training & Education										23
24	Travel and Seminar			580	580		580	1,656	2,236		24
25	Other Admin. Staff Transportation							43	43		25
26	Insurance-Prop.Liab.Malpractice			11,010	11,010		11,010	21	11,031		26
27	Other (specify):*										27
28	TOTAL General Administration	42,806	1,737	134,040	178,583		178,583	14,722	193,305		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	447,899	110,064	418,247	976,210	(1,186)	975,024	14,848	989,872		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number WEST MAIN NURSING HOME #0031757 Report Period Beginning: 10/1/00 Ending: 9/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			4,893	4,893		4,893	12,833	17,726			30
31	Amortization of Pre-Op. & Org.							78	78			31
32	Interest			172	172		172	39,551	39,723			32
33	Real Estate Taxes			4,678	4,678		4,678		4,678			33
34	Rent-Facility & Grounds			40,800	40,800		40,800	(38,813)	1,987			34
35	Rent-Equipment & Vehicles			1,543	1,543		1,543	1,352	2,895			35
36	Other (specify):*											36
37	TOTAL Ownership			52,086	52,086		52,086	15,001	67,087			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops		10		10		10		10			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			18,615	18,615		18,615		18,615			42
43	Other (specify):* LAB/RX					1,186	1,186		1,186			43
44	TOTAL Special Cost Centers		10	18,615	18,625	1,186	19,811		19,811			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	447,899	110,074	488,948	1,046,921		1,046,921	29,849	1,076,770			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number WEST MAIN NURSING HOME

0031757

Report Period Beginning: 10/1/00

Ending: 9/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(55)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(43)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(100)	21		18
19	Entertainment	(18)	24		19
20	Contributions	(96)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,687)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,161)	20		28
29	Other-Attach Schedule MISC INCOME	(1,512)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (4,672)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	34,521	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 34,521		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 29,849		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		10	10.2	42
43	Prescription Drugs	X		1,176	10.2	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 1,186		47

WEST MAIN NURSING HOMEID# 0031757Report Period Beginning: 10/1/00Ending: 9/30/01

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	MISC INCOME	\$ (1,512)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,512)		49

Summary A

0031757

Report Period Beginning:

10/1/00

Ending:

9/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JAMES J. GIARDINA	100%	MARKA NURSING HOME	MASCOUHAH	COMMUNITY	BALLWIN, MO	HOME OFFICE
		COMMUNITY CARE CENTER OF MONMOUTH	MONMOUTH	CARE CENTERS, INC		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	19 HOME OFFICE	\$ 36,360	COMMUNITY CARE CENTERS, INC	Common	\$ 59,164	\$ 22,804 1
2	V	34 BUILDING RENT	40,800	JAMES J. GIARDINA	100.00%		(40,800) 2
3	V	30 DEPRECIATION		JAMES J. GIARDINA	100.00%	12,833	12,833 3
4	V	32 INTEREST		JAMES J. GIARDINA	100.00%	39,606	39,606 4
5	V	31 AMORTIZATION		JAMES J. GIARDINA	100.00%	78	78 5
6	V						6
7	V						7
8	V						8
9	V						9
10	V						10
11	V						11
12	V						12
13	V						13
14	Total		\$ 77,160			\$ 111,681	\$ * 34,521 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WEST MAIN NURSING HOME # 0031757 Report Period Beginning: 10/1/00 Ending: 9/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JAMES J. GIARDINA	PRESIDENT	GEN. DIRECTOR	100.00	NONE	2	2.86	SALARY	\$ 21,639	17.7	1
2	DOROTHY GIARDINA	VICE PRES/SEC		0.00	NONE	1	2.50	SALARY	1,654	17.7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 23,293		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number **WEST MAIN NURSING HOME**# **0031757**

Report Period Beginning:

10/1/00

Ending:

9/30/01**VIII. ALLOCATION OF INDIRECT COSTS**

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization **COMMUNITY CARE CENTERS, INC**Street Address **312 SOLLEY DRIVE - REAR**City / State / Zip Code **BALLWIN, MO 63021**Phone Number **(636-394-3000**Fax Number **()**

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19 HOME OFFICE	DIRECT COST			\$	\$		\$	1
2	WEST COUNTY CARE CTR						4,457,330	260,966	2
3	ST GENEVIEVE CARE CTR						2,074,248	121,441	3
4	CCC OF LEMAY						1,977,853	115,799	4
5	SALEM CARE CENTER						1,609,925	94,257	5
6	MONMOUTH NH						1,408,605	82,469	6
7	MAR-KA NH						2,200,881	128,856	7
8	WEST MAIN NH						1,010,561	59,164	8
9	CCC OF SENECA						2,543,632	148,923	9
10	MT VERNON PLACE CARE						2,272,085	133,025	10
11	COUNTRY VIEW NH						1,896,074	111,010	11
12	MERAMEC NH						2,105,164	123,251	12
13	SEVILLE CARE CENTER						2,124,995	124,412	13
14	SALEM RES. CARE						437,359	25,605	14
15	BOSS RES. CARE						111,881	6,551	15
16	CARL JUNCTION RES. CARE						535,098	31,328	16
17	MT VERNON RES. CARE						318,166	18,629	17
18	SENECA HOME PLACE						379,101	22,196	18
19	HUDSON HOUSE						413,391	24,203	19
20	MAPLE GROVE LODGE						2,099,705	122,931	20
21	SMITH BARR MANOR						984,576	57,643	21
22	CCC OF AURORA						3,583,377	209,797	22
23	BARRY COMMUNITY CARE						1,856,648	108,701	23
24	COMMUNITY IN HOME						258,520	15,135	24
25	TOTALS				\$	\$		\$ 2,146,292	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	COLONIAL PACIFIC		X	COMPUTER SOFTWARE	\$137.00	6/97	\$	VARIOUS	\$	5/01	15.0000	\$	172	1
2	LEASING													2
3														3
4														4
5														5
	Working Capital													
6														6
7														7
8														8
9	TOTAL Facility Related				\$137.00		\$		\$			\$	172	9
	B. Non-Facility Related*													
10														10
11														11
12														12
13														13
14	TOTAL Non-Facility Related						\$		\$			\$		14
15	TOTALS (line 9+line14)						\$		\$			\$	172	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

B. Real Estate Taxes

NOTES:

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WEST MAIN NURSING HOME COUNTY ST. CLAIR

FACILITY IDPH LICENSE NUMBER 0031757

CONTACT PERSON REGARDING THIS REPORT YVONNE CHUA

TELEPHONE 636-394-3000 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. 10-31.0-111-038	LOT/SEC-3	\$ 4,420.00	\$ 4,420.00
2. _____	ALL LT 2 & ALL LT 3 BK	\$ _____	\$ _____
3. _____	2659-1974	\$ _____	\$ _____
4. 10-31.0-104-025	LOT/SEC-8-BLK/RG-1	\$ 258.00	\$ 258.00
5. _____	BK 2659-1974	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ 4,678.00	\$ 4,678.00

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

B. General Construction Type:
 Exterior
 BRICK
 Frame
 STEEL REINFRCD
 Number of Stories
 1

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☐ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY		1986	\$ 40,000	1
2					2
3	TOTALS			\$ 40,000	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	34		1986		\$ 385,000	\$	30	\$ 12,833	\$ 12,833	\$ 189,287	4
5			1987		7,106		10			7,106	5
6			1987		1,500		10			1,500	6
7											7
8											8
9	Improvement Type**										
10	ROOFING		1990		2,168	36	10	36		2,168	10
11											11
12	ROOFING		1993		2,550	255	10	255		2,103	12
13											13
14	ROOFING		1998		3,600	360	10	360		1,140	14
15											15
16	FLOORING		1999		5,346	267	20	267		668	16
17											17
18	FIRE SYSTEM		1999		1,352	54	25	54		117	18
19											19
20	ROOFTOP A/C		2000		3,650	730	5	730		974	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 412,272	\$ 1,702		\$ 14,535	\$ 12,833	\$ 205,063	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 21,499	\$ 3,064	\$ 3,064	\$	VARIOUS	\$ 13,195	71
72	Current Year Purchases	972	127	127		VARIOUS	127	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 22,471	\$ 3,191	\$ 3,191	\$		\$ 13,322	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	PATIENT TRAVEL	1995 FORD WINDSTAR	1995	\$ 17,138	\$	\$	\$	3	\$ 17,138	76
77										77
78										78
79										79
80	TOTALS			\$ 17,138	\$	\$	\$		\$ 17,138	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 491,881	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 4,893	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 17,726	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,833	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 235,523	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	ARCHITECTURAL DRAW.	\$ 3,387	92
93			93
94			94
95		\$ 3,387	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **RELATED PARTY LEASE**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ **1,543** Description: **DISHWASHER \$1,410; PAGERS \$133**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$

13. /2003 \$

14. /2004 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		32
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs		60	2,990		60	2,990		4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								
10	Academic Education		hrs								10
11	Exceptional Care Program										11
12											12
13	Other (specify):										13
14	TOTAL			\$	92	\$ 6,297	\$	92	\$ 6,297		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 23,747	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 2,500)	162,209		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,148		6
7	Other Prepaid Expenses	13,923		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): DUE FROM REL. PARTIES	46,102		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 252,129	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	18,666		15
16	Equipment, at Historical Cost	39,609		16
17	Accumulated Depreciation (book methods)	(37,630)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	3,387		22
23	Other(specify): DEPOSITS	2,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 26,032	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 278,161	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 23,820	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	26,295		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,902		31
32	Accrued Real Estate Taxes(Sch.IX-B)	3,420		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	38,522		35
	Other Current Liabilities(specify):			
36	DUE TO RELATED PARTY	419,456		36
37	PATIENT FUNDS PAYABLE	11,626		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 527,041	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 527,041	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (248,880)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 278,161	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (124,853)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (124,853)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(124,027)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (124,027)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (248,880)	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 921,403	1
2	Discounts and Allowances for all Levels	(10,451)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 910,952	3
B. Ancillary Revenue			
4	Day Care	1,512	4
5	Other Care for Outpatients		5
6	Therapy	9,871	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 11,383	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	504	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 504	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	55	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 55	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 922,894	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	242,709	31
32	Health Care	554,918	32
33	General Administration	178,583	33
B. Capital Expense			
34	Ownership	52,086	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	18,625	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,046,921	40
41	Income before Income Taxes (line 30 minus line 40)**	(124,027)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (124,027)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
 TAX RETURN
 ON CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

Page 20

Facility Name & ID Number WEST MAIN NURSING HOME

0031757

Report Period Beginning: 10/1/00

Ending:

9/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,627	1,627	\$ 29,560	\$ 18.17	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,914	1,970	33,753	17.13	3
4	Licensed Practical Nurses	4,653	4,950	62,019	12.53	4
5	Nurse Aides & Orderlies	11,792	12,310	116,546	9.47	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	580	620	5,624	9.07	8
9	Activity Director	1,986	2,256	21,746	9.64	9
10	Activity Assistants	208	208	1,914	9.20	10
11	Social Service Workers	672	672	5,719	8.51	11
12	Dietician					12
13	Food Service Supervisor	1,969	2,090	20,395	9.76	13
14	Head Cook	4,046	4,295	35,279	8.21	14
15	Cook Helpers/Assistants	1,446	1,535	9,097	5.93	15
16	Dishwashers					16
17	Maintenance Workers	967	1,024	7,753	7.57	17
18	Housekeepers	4,999	5,206	39,380	7.56	18
19	Laundry	2,187	2,220	16,249	7.32	19
20	Administrator	2,045	2,268	42,806	18.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	7	7	59	8.43	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	41,098	43,258	\$ 447,899 *	\$ 10.35	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	97	\$ 3,363	1.3	35
36	Medical Director	48	4,800	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	44	550	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	26	1,020	11.3	44
45	Social Service Consultant	26	1,020	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	241	\$ 10,753		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	4,405	128,052	10.3	51
52	Nurse Aides	5,236	93,026	10.3	52
53	TOTAL (lines 50 - 52)	9,641	\$ 221,078		53

Facility Name & ID Number **WEST MAIN NURSING HOME**# **0031757**Report Period Beginning: **10/1/00**Ending: **9/30/01****XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
MARY KEENAN	ADMINISTRATOR		\$ 42,806	Workers' Compensation Insurance	\$ 10,167	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	3,765	
				FICA Taxes	39,227	Health Care Worker Background Check		
				Employee Health Insurance	12,378	(Indicate # of checks performed 12)	144	
				Employee Meals		DUES AND SUBSCRIPTIONS	208	
				Illinois Municipal Retirement Fund (IMRF)*		TAXES AND LICENSES	1,285	
				OTHER EMPLOYEE BENEFITS	2,975	ADVERTISING OTHER	2,849	
				401K CONTRIBUTIONS	857			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 42,806	HOME OFFICE ALLOCATIONS	4,963	HOME OFFICE ALLOCATIONS	30	
(List each licensed administrator separately.)						Less: Public Relations Expense	(1,687)	
B. Administrative - Other						Non-allowable advertising	(1,161)	
Description			Amount			Yellow page advertising	()	
			\$					
				TOTAL (agree to Schedule V,	\$ 70,567			
				line 22, col.8)		TOTAL (agree to Sch. V,	\$ 5,433	
						line 20, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services							Out-of-State Travel	\$
Vendor/Payee	Type		Amount					
COMMUNITY CARE CENTERS, INC	MGMT FEES		36,360	NONE				
							In-State Travel	142
BKD, LLP	ACCOUNTING		5,110				MEALS	18
							Seminar Expense	420
							HOME OFFICE ALLOCATION	1,674
							Entertainment Expense	(18)
							(agree to Sch. V,	
							line 24, col. 8)	2,236
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$		
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 41,470					

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

[illegible]

Facility Name & ID Number WEST MAIN NURSING HOME

STATE OF ILLINOIS

0031757

Report Period Beginning:

10/1/00

Ending:

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9/30/01

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 3 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 46 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 18,615
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation. _____

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 70%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.